89-13

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No.

IN THE SUPREME COURT

OF THE UNITED STATES

OCTOBER TERM, 1988

OREGON PHYSICIANS' SERVICE,
an Oregon nonprofit corporation,

Petitioner,

v.

JOHN HAHN; WADE LIGGETT;
JOSEPH AIZAWA; V.G. LIVINGSTON;
HUGH FRASER; and HIDE AIZAWA,

Respondents.

APPENDIX TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

WILLIAM B. CROW
(Counsel of Record)
MARK ALEXANDER ANDERSON
MILLER, NASH, WIENER,
HAGER & CARLSEN
111 S.W. Fifth Avenue
Portland, Oregon 97204
Telephone: (503) 224-5858
Counsel for Oregon
Physicians' Service

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App. A

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

JOHN HAHN; WADE LIGGETT; JOSEPH AIZAWA; V.G. LIVINGSTON; HUGH FRASER; HIDE AIZAWA,	)	No. 87-3875
Plaintiffs-Appellants,	)	D.C. No. CV 78-0887 LE
v.	)	ORDER AND AMENDED OPINION
OREGON PHYSICIANS' SERVICE; PHYSICIANS' ASSOCIATION OF CLAKAMAS COUNTY,	)	
Defendants-Appellees.	)	

Appeal from the United States District Court
for the District of Oregon
Edward Leavy, District Judge, Presiding

Argued and Submitted
June 10, 1988 -- Portland, Oregon

Filed November 4, 1988
Amended February 27, 1989

Before: Procter Hug, Jr., Betty B. Fletcher and
Dorothy W. Nelson, Circuit Judges.

Opinion by Judge Fletcher

ORDER

The opinion filed November 4, 1988 and published at 860 F.2d 1501 (9th Cir. 1988) is amended as follows:

At page 13794 of the slip op. (860 F.2d at 1505), in the second paragraph of the section, STANDARD OF REVIEW, (1) insert before "*Barnes v. Arden Mayfair, Inc.*", "*Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 588 (1986)," (2) strike the last sentence of the paragraph.

At page 13800 of the slip opinion (860 F.2d at 1508), add the following as a new footnote, with the footnote call placed at the end of the second sentence in the second full paragraph (i.e. after the sentence that ends ". . . do not control the health care plan."):

> We recognize, however, that this rule may not be applicable to some health plans, such as health maintenance organizations, in which "persons who would otherwise be competitors pool their capital and share the risks of loss as well as the opportunities for profit. In such joint ventures, the partnership is regarded as a single firm competing with other sellers in the market." *Maricopa County*, 457 U.S. at 356. In such an arrangement, involving a "functionally integrated group of doctors," it is the doctors, rather than the patient or the insurer, who bear the economic risk. *Id.* at 339 n.7. Thus, for example, the Supreme Court has stated that "[i]f a clinic offered complete medical coverage for a flat fee, the cooperating doctors would have the type of partnership arrangement in which a price-fixing agreement among the doctors would be perfectly proper." *Id.* at 357. No such arrangement is present in this case.

At page 13802 of the slip opinion (860 F.2d at 1509), delete the second, third, and fourth sentences of the first full paragraph (i.e. the part beginning "Their evidence that physicians . . .") and substitute in their place the following:

> The appellants presented evidence by way of affidavit indicating that from 1975-81, physicians were responsible for 90% of foot care billings to OPS. This suggests that OPS member physicians are a significant competitive force in the Portland foot care market. Under these circumstances, we conclude that the appellants' evidence that physicians occupied a majority of the board seats supports an inference that OPS is controlled by competitive providers. In other words, the appellants have introduced sufficient evidence to permit a trier of fact to conclude that the OPS plan was, in fact, "an organization of physicians," *Barry*, 805 F.2d at 868, or an agent[ ] of [its] member physicians," *Virginia Academy*, 624 F.2d at 480. A trier of fact could reasonably conclude that the physician board members, even if not themselves competing directly with podiatrists, shared similar economic interests with those board members and OPS physicians who did compete directly, and that therefore the OPS board as a whole may have acted in the anticompetitive interests of those member physicians who compete with podiatrists for the provision of foot care.

At page 13806 of the slip opinion (860 F.2d at 1511), in the paragraph immediately preceding "CONCLUSION", delete line 5. The sentence as modified would read, "Whether ultimately the conduct can be sustained as justified or should be condemned, should be determined after a fully developed record at trial."

With these amendments, the panel has voted to deny the petition for rehearing. The full court has been advised of the suggestion for rehearing en banc and no active judge has requested a vote on whether to rehear the matter en banc. (Fed. R. App. P. 35)

The petition for rehearing is denied and the suggestion for rehearing en banc is rejected.

OPINION

FLETCHER, Circuit Judge:

Appellants appeal the district court's grant of summary judgment to appellees dismissing appellants' claim of violation of the Sherman Act, 15 U.S.C. § 1. We reverse and remand.

FACTS

Appellants are licensed doctors of podiatric medicine (D.P.M.'s) practicing in Oregon. Under state law, podiatrists are licensed to perform all foot procedures that medical doctors (M.D.'s) and doctors of osteopathic medicine (D.O.'s) may perform, except that they may not administer general or spinal anesthetics, or perform amputations. O.R.S. § 677.805(4).

Appellee Oregon Physicians' Service (OPS), founded by physicians, offers and administers a prepaid health care plan. At all relevant times, membership in OPS was limited to physicians and surgeons licensed to practice in Oregon. From 1974 to 1983, between 90 and 93 percent of all eligible M.D.'s and D.O.'s in Oregon were OPS members. In the same period, 16 percent of

the population of the Portland metropolitan area were subscribers.[1]

In the early 1970s, several of the appellants applied for membership in OPS, but were denied under OPS's policy of admitting only physicians. At that time, a majority of OPS's governing board of trustees were physicians. In 1982 the board contemplated extending membership to additional classes of providers, but decided to offer membership only to optometrists.

OPS offers many different policies to its subscribers, with varying terms. Under a majority of these policies, OPS offers a two-tier system covering health care costs. OPS conducts a survey of the fees for various services submitted to it by individual member physicians. Once the data has been compiled, the fees are referred to as the "usual, customary and reasonable" rates (UCR). OPS then determines the 90th percentile of such fees--that is, the rate at which 90 percent of the sample group charges the same or less.

When a member physician treats an OPS subscriber, OPS pays the physician directly up to the 90th percentile rate. The member physician must accept the OPS payment as payment in full and may not bill the subscriber for any extra amount. Nonmembers, on the other hand, may bill subscribers at whatever rate they choose. A subscriber pays a nonmember's bill and is then reimbursed by OPS, but generally at a rate no more than at the 60th percentile of the UCR. Nonmembers, unlike members, may bill subscribers for the balance of their fees. Appellants produced evidence that, on average,

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1 Although the parties may not be in complete agreement, appellants have apparently identified Portland as the proper geographic market for antitrust analysis.

OPS members received from OPS 76 cents on the dollar billed, while OPS paid podiatrists only 50 cents on the dollar billed. OPS subscribers were free to seek treatment from members or nonmembers as they wished.

In 1978, five of the appellants created the Fair Action Committee for Education, Inc. (FACE), a nonprofit corporation to which they assigned their antitrust claims against health care plans. FACE brought four separate antitrust actions against 12 prepaid health care plans in Oregon. In 1980, FACE was dissolved and the claims were reassigned to plaintiffs. Claims against five of the defendant health care plans were subsequently dismissed. The remaining seven defendants, including OPS, moved for summary judgment, alleging that their activity was exempt from the antitrust laws pursuant to the McCarran-Ferguson Act's exemption for the "business of insurance," 15 U.S.C. §§ 1011-1013, and arguing that plaintiffs had not shown sufficient impact on interstate commerce.

The district court granted defendants' motion for summary judgment. *Hahn v. Oregon Physicians' Serv.*, 508 F.Supp. 970 (D. Or. 1981). The Ninth Circuit reversed, holding that defendants' conduct was not exempted, but remanded for a finding as to the effect on interstate commerce. *Hahn v. Oregon Physicians' Serv.*, 689 F.2d 840 (9th Cir. 1982), *cert. denied*, 462 U.S. 1133 (1983). Appellants then settled with five of the remaining defendants.[2]

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[2] In 1983, OPS merged with Blue Cross of Oregon to form Blue Cross/Blue Shield of Oregon (BCBSO). As the survivor corporation, BCBSO expressly assumed all of OPS's rights, obligations and liabilities. In August 1985, BCBSO for the first time decided to allow podiatrists to become members. This later change in policy does not moot this action, however. *See Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 340 n.9 (1982).

In 1984, a trial was held on the impact of defendants' activities on interstate commerce. The district court found adequate impact to support federal antitrust jurisdiction. Appellants subsequently settled with the only remaining defendant other than OPS. On September 12, 1986, OPS moved for summary judgment. Appellants responded by moving for summary judgment in their favor or, in the alternative, for partial summary judgment. They also moved for leave to file an amended complaint naming BCBSO as defendant and appellants' professional corporations as plaintiffs.

On February 11, 1987, the district court granted summary judgment to OPS and denied all the motions appellants had filed in response. On April 24, appellants' motion to alter or amend the judgment was denied; the judgment dismissing their action was entered on May 1. Appellants timely appealed.

JURISDICTION

We assert jurisdiction over this appeal pursuant to 28 U.S.C. § 1291.

STANDARD OF REVIEW

We review a grant of summary judgment de novo, and will affirm if there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. *Barry v. Blue Cross of California*, 805 F.2d 866, 868 (9th Cir. 1986). Summary judgment is generally not favored in antitrust cases particularly because of their factual complexity, but it will be upheld if a plaintiff's complaint lacked any significant supporting evidence. *Klamath-Lake Pharm. Assoc. v. Klamath Med. Serv. Bureau*, 701 F.2d 1276, 1281-82 (9th Cir. 1983).

Where a plaintiff has alleged an illegal combination or conspiracy, a defendant seeking summary judgment has the burden of producing a plausible and justifiable explanation for its conduct that is consistent with proper business practices. Once the defendant has done so, the plaintiff must come forward with significant probative evidence capable of sustaining a reasonable inference that the defendant was not acting lawfully. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 588 (1986), *Barnes v. Arden Mayfair, Inc.*, 759 F.2d 676, 680 (9th Cir. 1985); *ALW, Inc. v. United Air Lines,* 510 F.2d 52, 55 (9th Cir. 1975).

DISCUSSION

Appellants argue that because they have adduced evidence that OPS was governed by a board controlled by physicians, that it expressly excluded non-physicians, and reimbursed nonmembers at a lower rate than members for the same services, they have made a prima facie case of a Section 1 violation.[3] Section 1 of the Sherman Act prohibits "[e]very contract, combination . . . or conspiracy, in restraint of trade." 15 U.S.C. § 1. To establish a section 1 violation, appellants must show three elements: (1) an agreement or conspiracy, (2) resulting in an unreasonable restraint of trade, and (3) causing antitrust injury. *Rickards v. Canine Eye Registration Fdn.*, 783 F.2d 1329, 1332 (9th Cir. 1986).

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3 In their original complaint, appellants raised claims under both 15 U.S.C. §§ 1 and 2, and the district court granted summary judgment under both sections. Appellants, however, state that they withdrew their section 2 claim shortly before OPS moved for summary judgment. They have not argued a section 2 theory on appeal. Brief of Appellants at 3 n.1.

Some practices are so likely to interfere with competition that courts have found them to be per se Sherman violations. The per se rule is invoked when a challenged activity facially appears to be one that would always or almost always tend to restrict competition and decrease output. *Id.*, citing *NCAA v. Board of Regents of Univ. of Okla.*, 468 U.S. 85, 100 (1984). Such practices include horizontal price-fixing, division of markets and certain group boycotts. *See, e.g., Northwest Wholesale Stationers v. Pacific Stationery*, 472 U.S. 284, 290 (1985) (group boycotts); *Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 343-45 (1982) (price-fixing); *United States v. Topco Associates, Inc.*, 405 U.S. 596, 608 (1972) (territorial market divisions).

Per se violations are a limited class, however, and it is much more common for courts to analyze questionable activities under the rule of reason. The rule of reason looks beyond the inherent anticompetitive potential of an activity and examines its actual effect in practice. It imposes on the plaintiff the burden of establishing that the practice in question unreasonably restrains competition. *Rickards*, 783 F.2d at 1333.

Since the effect on competition is the touchstone of rule of reason analysis, the intent of the defendants is relevant but not dispositive. *See NCAA*, 468 U.S. at 103; *Wilk v. AMA*, 719 F.2d 207, 225 (7th Cir. 1983). The existence of market power is a significant finding that casts an anticompetitive shadow over a party's practices in a rule-of-reason case. Ordinarily, it is an essential ingredient in a rule-of-reason case. Not so, however, where the conduct should be viewed as a per se violation. "[T]he absence of proof of market power does not justify a naked restriction on price or output." *NCAA*, 468 U.S. at 109.

Appellants allege that OPS's practices violate the Sherman Act in two ways: (1) as a horizontal price-fixing agreement; and (2) as a group boycott of podiatrists. Both such practices, they assert, constitute per se violations of Section 1. We address these claims in turn.

A. *Price Fixing.*

Appellants argue that by setting a fee schedule of maximum rates of reimbursement, OPS has engaged in horizontal price-fixing. They claim that OPS's two-tier reimbursement system forces them to compete on unfavorable terms with member physicians. OPS pays member physicians directly at the 90th percentile rate and bars them from charging subscribers any more. Nonmembers, by contrast, must bill subscribers, who are then reimbursed by OPS, but usually only at the 60th percentile rate. To subscribers, then, the services of member physicians are available at no cost beyond their subscription costs. The services of nonmembers, however, may be available to subscribers only at additional out-of-pocket cost to subscribers unless the nonmembers-podiatrists are willing to accept the rate at which OPS will reimburse as payment in full. Appellants contend OPS's billing and reimbursement practices have cost them both revenue and patients. Further, they claim they cannot compete with OPS members on these terms. Since OPS does not permit them to become members, the practices adversely affect competition.

In *Maricopa County*, 457 U.S. 332, member doctors of a medical society by agreement established maximum fees. The Maricopa Foundation operated similarly to OPS; it drew up a schedule of maximum fees, which participating doctors agreed to accept as payment in full for insured patients. *Id.* at 339. Insured patients were free to

go to nonmember physicians, but were obligated individually to pay any excess that nonmembers charged above the fee schedule. *Id.* at 341.

The Court found the practice to be a per se violation of Section 1. That the agreement was intended to set a ceiling on prices rather than a floor did not make it any the less price-fixing. "The *per se* rule 'is grounded on faith in price competition as a market force [and not] on a policy of low selling prices at the price of eliminating competition.' " *Id.* at 348 (citation omitted). The Court found particularly objectionable the fact that doctors who might otherwise have been in competition had made the agreement. "Even if a fee schedule is [ ] desirable, it is not necessary that the doctors do the price fixing," the Court observed, and distinguished by way of example another insurance program of the Maricopa Foundation that was administered by a state agency rather than by doctors. *Id.* at 352-53. The Court expressly stated that it was not deciding "whether an *insurer* may, consistent with the Sherman Act, fix the fee schedule and enter into bilateral contracts with individual doctors." *Id.* at 353 n.26 (emphasis added). The Court noted that it had also not reached the issue in *Group Life & Health Ins. v. Royal Drug Co.*, 440 U.S. 205 (1979). *Id.*

In *Royal Drug*, a group of independent pharmacists brought an antitrust action against Blue Shield of Texas for reimbursing subscribers at a higher rate when they bought from participating pharmacies than when they patronized non-participating pharmacies. Blue Shield had offered such an agreement to every pharmacy in the state. On remand from the Supreme Court, the Fifth Circuit answered the open question in the affirmative, distinguishing *Maricopa County* on the ground that the agreements did not run "between competitors in the pharmaceutical industry, nor between competitors in the

insurance industry, but between individual pharmacies and Blue Shield, which does not compete with pharmacies." *Royal Drug Co. v. Group Life & Health Ins.*, 737 F.2d 1433, 1436-37 (5th Cir. 1984). The court read *Maricopa County* not as a blanket condemnation of maximum medical fees, but as an affirmation that doctors may not, as *competitors*, horizontally enter into agreements to establish fees.

This circuit has agreed. In *Barry v. Blue Cross,* 805 F.2d 866, Blue Cross of California contracted with physicians to provide services to subscribers at a fixed rate to be set by Blue Cross. By statute, no more than one-third of Blue Cross's governing board could be physicians. Member physicians were reimbursed at 90 percent of the UCR, nonmembers at 60-70 percent. Both subscribers and members were free to deal with any patient, physician, or other insurer; the only restriction was that a member physician could not refer a subscriber to a nonmember without the subscriber's consent. *Id.* at 867-68.

We dismissed a Section 1 challenge to Blue Cross's practice. We did not consider *Maricopa County* controlling because we found no evidence to suggest that physicians controlled the Blue Cross plan; of the 126 members of various Blue Cross boards of directors, advisors, and senior staff, only 22 were physicians. *Id.* at 868-69. As a result, we found that the plan did not offend the antitrust laws under either a per se or a rule of reason analysis. *Id.* at 870.

The Fourth Circuit, however, applying a rule of reason analysis, held that the refusal of Blue Shield of Virginia to pay for services rendered by clinical psychologists unless they were billed through physicians violated the antitrust laws. *Virginia Acad. of Clinical Psychologists v. Blue Shield of Va.,* 624 F.2d 476 (4th Cir. 1980). Blue

Shield argued that its decision was unilateral, and that a corporation cannot conspire with itself under the anti-trust laws. Plaintiffs, on the other hand, contended that Blue Shield plans were nothing more than combinations of physicians. *Id.* at 479, 481. The court agreed with plaintiffs, finding that "in a real and legal sense, the Blue Shield Plans are agents of their member physicians." *Id.* at 480. Looking "at substance rather than form," the court held that since the bylaws of Blue Cross of Virginia required a majority of its board of directors to be physicians, there was sufficient physician control of the organization to make Blue Cross's restrictions on payments to clinical psychologists a violation of the Sherman Act.[4] *Id.* at 480-81.

In a case in which non-member dentists who considered themselves disadvantaged by a prepaid dental plan of Blue Shield challenged the plan, the Third Circuit looked to the influence of dentists over Blue Shield's policies, rather than to that of doctors. *Pennsylvania Dental Assoc. v. Medical Serv. Assoc. of Pa.*, 745 F.2d 248 (3d Cir. 1984). The plan was similar to the plans for doctors--member dentists agreed to accept a set percentage of the UCR as full payment for treating Blue Shield subscribers. A subscriber's payments to a non-member dentist would be reimbursed at the same rate, but the subscriber would be personally responsible for amounts charged above the UCR. *Id.* at 253.

The bylaws of Blue Shield provided for a board comprised of 16 lay persons and 16 doctors. Only two members of the 32 were dentists. *Id.* The Third Circuit held that to sustain its claim, the plaintiff would have to

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4 Although the decision in *Virginia Academy* predates *Maricopa County* by two years, the Fourth Circuit's opinion followed substantially similar reasoning.

show that member dentists, through their majority membership on two Blue Shield committees, actually controlled the UCR system. *Id.* at 256. Since it found that the committees were advisory only and real control was vested in the board, and since dentists accounted for only one-sixteenth of that body, the court upheld the district court's grant of summary judgment. *Id.* at 258-59. The court distinguished *Virginia Academy*, noting that the evidence in that case tended to show physician control. *Id.* at 257.

In the case before us, the district court granted summary judgment to OPS on the price-fixing claim on the ground that the majority of the OPS board, although physicians, did not compete economically with appellants for the provision of foot care in the relevant market. The court also found no evidence that any OPS members who did compete with appellant had conspired with OPS trustees. The court also ruled as a matter of law that under *Barry*, "health care plans like the OPS/BCBSO plan described here do not violate antitrust laws."

On the record before us, we cannot agree. Read together, *Maricopa County, Barry, Royal Drug, Virginia Academy* and *Pennsylvania Dental* stand for the broad proposition that health care plans may reimburse members and nonmembers differently, both in price and manner, so long as physicians (or the relevant group of competitive providers) do not control the health care plan.[5] In *Barry*, it was because the plaintiffs had failed to

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5 We recognize, however, that this rule may not be applicable to some health plans, such as health maintenance organizations, in which "persons who would otherwise be competitors pool their capital and share the risks of loss as well as the opportunities for profit. In such joint ventures, the partnership is regarded as a single firm competing with other sellers in

produce any evidence of physician control of the price-setting entity that we upheld the agreement as to prices and reimbursement. We fully recognized, however, that "a horizontal agreement among competing physicians . . . is per se unlawful under section 1" and *Maricopa*. *Barry*, 805 F.2d at 868. Likewise, *Royal Drug* upheld the challenged practice because it did not arise from an agreement "between *competitors*." *Royal Drug*, 737 F.2d at 1436 (emphasis added). Conversely, the *Virginia Academy* court did find proscribed activity where the health plans at issue were mere "agents of their member physicians." *Virginia Academy*, 624 F.2d at 480.

Based on the evidence plaintiffs have so far produced, their case is more akin to *Maricopa* than to *Barry*. They have shown, for instance, that physicians formed a majority of the board for many of the years in question.[6] They have also alleged that physicians who practice in any of 20 specialties perform procedures that podiatrists

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(Footnote 5 continued)

the market." *Maricopa County*, 457 U.S. at 356. In such an arrangement, involving a "functionally integrated group of doctors," it is the doctors, rather than the patient or the insurer, who bear the economic risk. *Id.* at 339 n.7. Thus, for example, the Supreme Court has stated that "[i]f a clinic offered complete medical coverage for a flat fee, the cooperating doctors would have the type of partnership arrangement in which a price-fixing agreement among the doctors would be perfectly proper." *Id.* at 357. No such arrangement is present in this case.

6 The district court found that a 1978 amendment to the OPS bylaws required 50 percent non-physician members on the OPS board.

perform.[7] Accordingly, many doctors are direct competitors to podiatrists, at least as to some of their services.

The district court stated that the majority of the OPS board did not, in fact, compete economically with the appellants in Portland. The court found that on a "typical" OPS board in the relevant years, a majority of trustees did not practice in Portland, and that many others had retired from practice. Accordingly, it concluded that a majority of trustees "would have no economic interest in restraining trade in the provision of foot care services in Portland."

Even if board members did not compete directly with the appellants, it cannot be determined as a matter of law that the board members had no economic interest in restraining trade. The proper inquiry is not whether individual board members *themselves* were in actual competition with the complaining nonmembers. Rather, the proper inquiry is whether practitioners sharing substantially similar economic interests collectively exercised control of a plan under whose auspices they have reached agreements which work to the detriment of competitors.

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7 The twenty listed specialties are: "(1) allergists, (2) anesthesiologists, (3) cardiovascular disease specialists and surgeons, (4) dermatologists, (5) endocrinologists, (6) family practitioners, (7) geriatric specialists, (7a) hematologists, (8) general practitioners, (9) diagnosis and internal medicine specialists, (10) infectious disease specialists, (10a) industrial practice specialists, (11) neurologists and neurosurgeons (12) oncologists, (13) orthopedic surgeons, (14) pathologists, (14a) physical medicine-rehabilitation specialists, (15) pediatricians, (16) plastic surgeons, (17) radiologists, (18) rheumatologists, (19) general surgeons, and (20) vascular surgeons." Brief of appellants, at 14.

See generally *Maricopa County*, 457 U.S. 332.[8] The challenged plan in *Barry* passed muster because it was "not an organization of physicians." *Barry*, 805 F.2d at 868. Similarly, the fact that physicians held half of the board seats in *Pennsylvania Dental* was irrelevant where the only potential competitors of the plaintiffs--dentists--held but two of 32 seats. Indeed, the *Pennsylvania Dental* court contrasted the dentists' negligible power with the physicians' controlling position in *Virginia Academy*. *Pennsylvania Dental*, 745 F.2d at 257.

Appellants in this case have made a sufficient factual showing to survive summary judgment. The appellants presented evidence by way of affidavit indicating that from 1975-81, physicians were responsible for 90% of foot care billings to OPS. This suggests that OPS member physicians are a significant competitive force in the Portland foot care market. Under these circumstances, we conclude that the appellants' evidence that physicians occupied a majority of the board seats supports an inference that OPS is controlled by competitive providers. In other words, the appellants have introduced sufficient evidence to permit a trier of fact to conclude that the OPS plan was, in fact, "an organization of physicians," *Barry*, 805 F.2d at 868, or an agent[ ] of [its] member physicians," *Virginia Academy*, 624 F.2d at 480. A trier of fact could reasonably conclude that the physician board members, even if not themselves competing directly with podiatrists, shared similar economic

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8 *See also Radiant Burners, Inc. v. Peoples Gas, Light & Coke Co.*, 364 U.S. 656, 657 n.1, 659-60 (1961) (though only six among "numerous" members of gas association directly competed with plaintiff, Sherman 1 claim was stated even in absence of proof that six direct competitors controlled association, because association members as a whole shared substantially similar economic interests).

interests with those board members and OPS physicians who did compete directly, and that therefore the OPS board as a whole may have acted in the anticompetitive interests of those member physicians who compete with podiatrists for the provision of foot care. The lack of evidence of an overt conspiracy is not dispositive. If the OPS plan was, in fact, a horizontal agreement among competitors, it was unlawful per se. *See Barry*, 805 F.2d at 868.

We conclude that, construing the evidence in the light most favorable to appellants, the district court acted precipitously in ruling as a matter of law that they were not entitled to judgment.

B. *Group Boycott*

Appellants also claim that they have made a prima facie showing that the exclusion of podiatrists from OPS, taken together with the discriminatory reimbursement policies for their services as non-members, constitutes a "group boycott" under Section 1.

Group boycotts, sometimes called concerted refusals to deal, commonly are considered business practices that merit per se invalidation under section 1. *Northwest Wholesale*, 472 U.S. at 290. However, the Supreme Court has cautioned lower courts not to be overinclusive in defining the categories of refusals to deal that amount to per se violations. "Cases to which this Court has applied the *per se* approach have generally involved joint efforts by a firm or firms to disadvantage competitors by 'either directly denying or persuading or coercing suppliers or customers to deny relationships the competitors need in the competitive struggle.' " *Id.* at 294, quoting L. Sullivan, Law of Antitrust 261-62 (1977).

Northwest Wholesale identified three characteristics as indicative of per se illegal boycotts: (1) the boycott cuts off access to a supply, facility, or market necessary to enable the victim firm to compete; (2) the boycotting firm possesses a dominant market position; and (3) the practices are not justified by plausible arguments that they enhanced overall efficiency or competition. *Id.* Under these or similar circumstances, the Court held, the danger of anticompetitive injury was sufficiently great that per se treatment was warranted. *Id.*[9]

In the absence of such a showing, however, the Court has since admonished that the category of activities comprising group boycotts "is not to be expanded indiscriminately." *FTC v. Indiana Federation of Dentists,* 476 U.S. 447, 458 (1986). Of particular relevance to this case, the Court added: "Moreover, we have been slow to condemn rules adopted by professional associations as unreasonable *per se* . . . and, in general, to extend *per se* analysis to restraints imposed in the context of business relationships where the economic impact of certain practices is not immediately obvious." *Id.* at 458-59.

However, the Court has not evidenced a similar reluctance to apply a rule of reason analysis to strike down rules of professional associations. In *Indiana Federation of Dentists*, the dentists formed a federation to continue the Indiana Dental Association's former policy of refusing to submit x-rays to dental health insurers with dental claim forms. Insurers requested the x-rays so that their administrators could determine whether the recommended course of treatment was reasonable. Applying a

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9 The Court's approach seems to suggest that the facts be developed as in a rule of reason case, or at least almost as fully, in order to determine whether the conduct is per se illegal.

rule of reason test, the Court ruled that the Federation's practice violated the antitrust laws.

Barry is instructive on the approach in this circuit to group boycott claims against professional organizations. The court applied rule of reason analysis to determine the effect on competition of Blue Cross's agreement with physicians. The *Barry* plaintiffs argued that the Blue Cross plan had the effect of boycotting nonmember physicians by interfering with their access to subscribers. Since nonmember services were reimbursed at a lower rate, the difference to be paid by the individual patient, they contended, few patients would consent to referral to a nonmember; this was tantamount to a refusal to deal. We rejected this argument, reasoning that the diversion of patients from other physicians was little different from

> the ordinary consequence of every commercial contract . . . When a consumer contracts to buy services from one health plan, the consumer will then have little or no demand for the services of a nonparticipating physician, especially if the consumer would have to pay more for those services. The contract does not mean that the parties have agreed to an unlawful concerted refusal to deal.

Barry, 805 F.2d at 872. In upholding the practice, however, we took pains to distinguish *Virginia Academy*, in which there was also an allegation of boycott:

> [i]n that case, Blue Shield reimbursed for psychologists' services only when billed through a member physician. Psychiatrists, who compete with psychologists, did not face this obstacle because, as medical doctors, they could simply become members of Blue Shield. By contrast, in the present case, Blue Cross *does not discriminate* against a

particular class of medical provider, but instead is willing to purchase services from all physicians on equal terms.

Id. at 873 (emphasis added).

Obviously, the fact that OPS *does* discriminate against a class of providers distinguishes this case from *Barry*. While, standing alone, OPS's two-tier fee system could probably withstand a "boycott" challenge under *Barry*, when coupled with OPS's long refusal to admit podiatrists, it is doubtful whether OPS was, in fact, "willing to purchase services from all [practitioners] on equal terms." *Id.*

OPS has the burden under *Barnes* of putting forward a plausible, justifiable explanation for its conduct. It stipulated that it would "not defend this case in any way on the basis that the quality of health care provided by podiatrists is inferior to that provided by other providers of health care." Instead, it claims that "problems with podiatrist claims overutilization"[10] motivated its decision to exclude podiatrists from membership. Brief of Appellee at 9. Even if this is a plausible and legitimate basis for exclusion, we find that appellants sustained their burden under *Barnes* of raising a reasonable inference, grounded in evidence, to refute OPS's claimed justification. Again without deciding any factual issues, we note that the record includes testimony from a former OPS board member, Dr. Price, suggesting that the exclusion of podiatrists was prompted neither by considerations of cost nor by fears of overbilling. Appellants have also produced evidence that the overall costs for foot procedures

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10 It is unclear whether the contention is that patients sought unnecessary care or that podiatrists performed unnecessary procedures.

performed by podiatrists were lower than those of OPS members. *See* Reply Brief of Appellants at 13-14.

Viewing the evidence in the light most favorable to appellants, we must conclude that they are entitled to go to trial on their group boycott theory. Whether ultimately the conduct can be sustained as justified or should be condemned, should be determined after a fully developed record at trial. Summary judgment should not have been granted.

CONCLUSION

Appellants asked that we direct the district court to enter summary judgment in their favor. We conclude that genuine issues of material fact remain. In such a case that is rife with factual complexity, summary judgment for either side is rarely justified. *See Barnes*, 759 F.2d at 681. Accordingly, we decline appellants' invitation, reverse the summary judgment in favor of OPS and remand for trial.

REVERSED and REMANDED.

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

JOHN HAHN; WADE LIGGETT; JOSEPH AIZAWA; V.G. LIVINGSTON; HUGH FRASER; HIDE AIZAWA,	) No. 87-3875
Plaintiffs-Appellants,	) D.C. No. CV 78-0887 LE
v.	) OPINION
OREGON PHYSICIANS' SERVICE; PHYSICIANS' ASSOCIATION OF CLAKAMAS COUNTY,	)
Defendants-Appellees.	)

Appeal from the United States District Court
for the District of Oregon
Edward Leavy, District Judge, Presiding

Argued and Submitted
June 10, 1988 -- Portland, Oregon

Filed November 4, 1988

Before: Procter Hug, Jr., Betty B. Fletcher and Dorothy W. Nelson, Circuit Judges.

Opinion by Judge Fletcher

OPINION

FLETCHER, Circuit Judge:

Appellants appeal the district court's grant of summary judgment to appellees dismissing appellants' claim of violation of the Sherman Act, 15 U.S.C. § 1. We reverse and remand.

FACTS

Appellants are licensed doctors of podiatric medicine (D.P.M.'s) practicing in Oregon. Under state law, podiatrists are licensed to perform all foot procedures that medical doctors (M.D.'s) and doctors of osteopathic medicine (D.O.'s) may perform, except that they may not administer general or spinal anesthetics, or perform amputations. O.R.S. § 677.805(4).

Appellee Oregon Physicians' Service (OPS), founded by physicians, offers and administers a prepaid health care plan. At all relevant times, membership in OPS was limited to physicians and surgeons licensed to practice in Oregon. From 1974 to 1983, between 90 and 93 percent of all eligible M.D.'s and D.O.'s in Oregon were OPS members. In the same period, 16 percent of the population of the Portland metropolitan area were subscribers.[1]

In the early 1970s, several of the appellants applied for membership in OPS, but were denied under OPS's policy of admitting only physicians. At that time, a majority of OPS's governing board of trustees were physi-

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[1] Although the parties may not be in complete agreement, appellants have apparently identified Portland as the proper geographic market for antitrust analysis.

cians. In 1982 the board contemplated extending membership to additional classes of providers, but decided to offer membership only to optometrists.

OPS offers many different policies to its subscribers, with varying terms. Under a majority of these policies, OPS offers a two-tier system covering health care costs. OPS conducts a survey of the fees for various services submitted to it by individual member physicians. Once the data has been compiled, the fees are referred to as the "usual, customary and reasonable" rates (UCR). OPS then determines the 90th percentile of such fees--that is, the rate at which 90 percent of the sample group charges the same or less.

When a member physician treats an OPS subscriber, OPS pays the physician directly up to the 90th percentile rate. The member physician must accept the OPS payment as payment in full and may not bill the subscriber for any extra amount. Nonmembers, on the other hand, may bill subscribers at whatever rate they choose. A subscriber pays a nonmember's bill and is then reimbursed by OPS, but generally at a rate no more than at the 60th percentile of the UCR. Nonmembers, unlike members, may bill subscribers for the balance of their fees. Appellants produced evidence that, on average, OPS members received from OPS 76 cents on the dollar billed, while OPS paid podiatrists only 50 cents on the dollar billed. OPS subscribers were free to seek treatment from members or nonmembers as they wished.

In 1978, five of the appellants created the Fair Action Committee for Education, Inc. (FACE), a nonprofit corporation to which they assigned their antitrust claims against health care plans. FACE brought four separate antitrust actions against 12 prepaid health care

plans in Oregon. In 1980, FACE was dissolved and the claims were reassigned to plaintiffs. Claims against five of the defendant health care plans were subsequently dismissed. The remaining seven defendants, including OPS, moved for summary judgment, alleging that their activity was exempt from the antitrust laws pursuant to the McCarran-Ferguson Act's exemption for the "business of insurance," 15 U.S.C. §§ 1011-1013, and arguing that plaintiffs had not shown sufficient impact on interstate commerce.

The district court granted defendants' motion for summary judgment. *Hahn v. Oregon Physicians' Serv.*, 508 F.Supp. 970 (D. Or. 1981). The Ninth Circuit reversed, holding that defendants' conduct was not exempted, but remanded for a finding as to the effect on interstate commerce. *Hahn v. Oregon Physicians' Serv.*, 689 F.2d 840 (9th Cir. 1982), *cert. denied*, 462 U.S. 1133 (1983). Appellants then settled with five of the remaining defendants.[2]

In 1984, a trial was held on the impact of defendants' activities on interstate commerce. The district court found adequate impact to support federal antitrust jurisdiction. Appellants subsequently settled with the only remaining defendant other than OPS. On September 12, 1986, OPS moved for summary judgment. Appellants responded by moving for summary judgment in their favor or, in the alternative, for partial summary

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2 In 1983, OPS merged with Blue Cross of Oregon to form Blue Cross/Blue Shield of Oregon (BCBSO). As the survivor corporation, BCBSO expressly assumed all of OPS's rights, obligations and liabilities. In August 1985, BCBSO for the first time decided to allow podiatrists to become members. This later change in policy does not moot this action, however. *See Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 340 n.9 (1982).

judgment. They also moved for leave to file an amended complaint naming BCBSO as defendant and appellants' professional corporations as plaintiffs.

On February 11, 1987, the district court granted summary judgment to OPS and denied all the motions appellants had filed in response. On April 24, appellants' motion to alter or amend the judgment was denied; the judgment dismissing their action was entered on May 1. Appellants timely appealed.

JURISDICTION

We assert jurisdiction over this appeal pursuant to 28 U.S.C. § 1291.

STANDARD OF REVIEW

We review a grant of summary judgment de novo, and will affirm if there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. *Barry v. Blue Cross of California*, 805 F.2d 866, 868 (9th Cir. 1986). Summary judgment is generally not favored in antitrust cases particularly because of their factual complexity, but it will be upheld if a plaintiff's complaint lacked any significant supporting evidence. *Klamath-Lake Pharm. Assoc. v. Klamath Med. Serv. Bureau*, 701 F.2d 1276, 1281-82 (9th Cir. 1983).

Where a plaintiff has alleged an illegal combination or conspiracy, a defendant seeking summary judgment has the burden of producing a plausible and justifiable explanation for its conduct that is consistent with proper business practices. Once the defendant has done so, the plaintiff must come forward with significant probative evidence capable of sustaining a reasonable inference that the defendant was not acting lawfully. *Barnes v.*

Arden Mayfair, Inc., 759 F.2d 676, 680 (9th Cir. 1985); *ALW, Inc. v. United Air Lines*, 510 F.2d 52, 55 (9th Cir. 1975). If the evidence could support both an inference of conspiracy and one of lawful conduct, summary judgment is inappropriate. *Barnes*, 759 F.2d at 681.

DISCUSSION

Appellants argue that because they have adduced evidence that OPS was governed by a board controlled by physicians, that it expressly excluded non-physicians, and reimbursed nonmembers at a lower rate than members for the same services, they have made a prima facie case of a Section 1 violation.[3] Section 1 of the Sherman Act prohibits "[e]very contract, combination . . . or conspiracy, in restraint of trade." 15 U.S.C. § 1. To establish a section 1 violation, appellants must show three elements: (1) an agreement or conspiracy, (2) resulting in an unreasonable restraint of trade, and (3) causing antitrust injury. *Rickards v. Canine Eye Registration Fdn.*, 783 F.2d 1329, 1332 (9th Cir. 1986).

Some practices are so likely to interfere with competition that courts have found them to be per se Sherman violations. The per se rule is invoked when a challenged activity facially appears to be one that would always or almost always tend to restrict competition and decrease output. *Id.*, citing *NCAA v. Board of Regents of*

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3 In their original complaint, appellants raised claims under both 15 U.S.C. §§ 1 and 2, and the district court granted summary judgment under both sections. Appellants, however, state that they withdrew their section 2 claim shortly before OPS moved for summary judgment. They have not argued a section 2 theory on appeal. Brief of Appellants at 3 n.1.

Univ. of Okla., 468 U.S. 85, 100 (1984). Such practices include horizontal price-fixing, division of markets and certain group boycotts. *See, e.g., Northwest Wholesale Stationers v. Pacific Stationery*, 472 U.S. 284, 290 (1985) (group boycotts); *Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 343-45 (1982) (price-fixing); *United States v. Topco Associates, Inc.*, 405 U.S. 596, 608 (1972) (territorial market divisions).

Per se violations are a limited class, however, and it is much more common for courts to analyze questionable activities under the rule of reason. The rule of reason looks beyond the inherent anticompetitive potential of an activity and examines its actual effect in practice. It imposes on the plaintiff the burden of establishing that the practice in question unreasonably restrains competition. *Rickards*, 783 F.2d at 1333.

Since the effect on competition is the touchstone of rule of reason analysis, the intent of the defendants is relevant but not dispositive. *See NCAA*, 468 U.S. at 103; *Wilk v. AMA*, 719 F.2d 207, 225 (7th Cir. 1983). The existence of market power is a significant finding that casts an anticompetitive shadow over a party's practices in a rule-of-reason case. Ordinarily, it is an essential ingredient in a rule-of-reason case. Not so, however, where the conduct should be viewed as a per se violation. "[T]he absence of proof of market power does not justify a naked restriction on price or output." *NCAA*, 468 U.S. at 109.

Appellants allege that OPS's practices violate the Sherman Act in two ways: (1) as a horizontal price-fixing agreement; and (2) as a group boycott of podiatrists. Both such practices, they assert, constitute per se violations of Section 1. We address these claims in turn.

A. *Price Fixing.*

Appellants argue that by setting a fee schedule of maximum rates of reimbursement, OPS has engaged in horizontal price-fixing. They claim that OPS's two-tier reimbursement system forces them to compete on unfavorable terms with member physicians. OPS pays member physicians directly at the 90th percentile rate and bars them from charging subscribers any more. Nonmembers, by contrast, must bill subscribers, who are then reimbursed by OPS, but usually only at the 60th percentile rate. To subscribers, then, the services of member physicians are available at no cost beyond their subscription costs. The services of nonmembers, however, may be available to subscribers only at additional out-of-pocket cost to subscribers unless the nonmember-podiatrists are willing to accept the rate at which OPS will reimburse as payment in full. Appellants contend OPS's billing and reimbursement practices have cost them both revenue and patients. Further, they claim they cannot compete with OPS members on these terms. Since OPS does not permit them to become members, the practices adversely affect competition.

In *Maricopa County*, 457 U.S. 332, member doctors of a medical society by agreement established maximum fees. The Maricopa Foundation operated similarly to OPS; it drew up a schedule of maximum fees, which participating doctors agreed to accept as payment in full for insured patients. *Id.* at 339. Insured patients were free to go to nonmember physicians, but were obligated individually to pay any excess that nonmembers charged above the fee schedule. *Id.* at 341.

The Court found the practice to be a per se violation of Section 1. That the agreement was intended to set

a ceiling on prices rather than a floor did not make it any the less price-fixing. "The *per se* rule 'is grounded on faith in price competition as a market force [and not] on a policy of low selling prices at the price of eliminating competition.' " *Id.* at 348 (citation omitted). The Court found particularly objectionable the fact that doctors who might otherwise have been in competition had made the agreement. "Even if a fee schedule is [ ] desirable, it is not necessary that the doctors do the price fixing," the Court observed, and distinguished by way of example another insurance program of the Maricopa Foundation that was administered by a state agency rather than by doctors. *Id.* at 352-53. The Court expressly stated that it was not deciding "whether an *insurer* may, consistent with the Sherman Act, fix the fee schedule and enter into bilateral contracts with individual doctors." *Id.* at 353 n.26 (emphasis added). The Court noted that it had also not reached the issue in *Group Life & Health Ins. v. Royal Drug Co.*, 440 U.S. 205 (1979). *Id.*

In *Royal Drug*, a group of independent pharmacists brought an antitrust action against Blue Shield of Texas for reimbursing subscribers at a higher rate when they bought from participating pharmacies than when they patronized non-participating pharmacies. Blue Shield had offered such an agreement to every pharmacy in the state. On remand from the Supreme Court, the Fifth Circuit answered the open question in the affirmative, distinguishing *Maricopa County* on the ground that the agreements did not run "between competitors in the pharmaceutical industry, nor between competitors in the insurance industry, but between individual pharmacies and Blue Shield, which does not compete with pharmacies." *Royal Drug Co. v. Group Life & Health Ins.*, 737 F.2d 1433, 1436-37 (5th Cir. 1984). The court read *Maricopa County* not as a blanket condemnation of maximum

medical fees, but as an affirmation that doctors may not, as *competitors*, horizontally enter into agreements to establish fees.

This circuit has agreed. In *Barry v. Blue Cross*, 805 F.2d 866, Blue Cross of California contracted with physicians to provide services to subscribers at a fixed rate to be set by Blue Cross. By statute, no more than one-third of Blue Cross's governing board could be physicians. Member physicians were reimbursed at 90 percent of the UCR, nonmembers at 60-70 percent. Both subscribers and members were free to deal with any patient, physician, or other insurer; the only restriction was that a member physician could not refer a subscriber to a nonmember without the subscriber's consent. *Id.* at 867-68.

We dismissed a Section 1 challenge to Blue Cross's practice. We did not consider *Maricopa County* controlling because we found no evidence to suggest that physicians controlled the Blue Cross plan; of the 126 members of various Blue Cross boards of directors, advisors, and senior staff, only 22 were physicians. *Id.* at 868-69. As a result, we found that the plan did not offend the antitrust laws under either a per se or a rule of reason analysis. *Id.* at 870.

The Fourth Circuit, however, applying a rule of reason analysis, held that the refusal of Blue Shield of Virginia to pay for services rendered by clinical psychologists unless they were billed through physicians violated the antitrust laws. *Virginia Acad. of Clinical Psychologists v. Blue Shield of Va.*, 624 F.2d 476 (4th Cir. 1980). Blue Shield argued that its decision was unilateral, and that a corporation cannot conspire with itself under the antitrust laws. Plaintiffs, on the other hand, contended that Blue Shield plans were nothing more than combinations

of physicians. *Id.* at 479, 481. The court agreed with plaintiffs, finding that "in a real and legal sense, the Blue Shield Plans are agents of their member physicians." *Id.* at 480. Looking "at substance rather than form," the court held that since the bylaws of Blue Cross of Virginia required a majority of its board of directors to be physicians, there was sufficient physician control of the organization to make Blue Cross's restrictions on payments to clinical psychologists a violation of the Sherman Act.[4] *Id.* at 480-81.

In a case in which non-member dentists who considered themselves disadvantaged by a prepaid dental plan of Blue Shield challenged the plan, the Third Circuit looked to the influence of dentists over Blue Shield's policies, rather than to that of doctors. *Pennsylvania Dental Assoc. v. Medical Serv. Assoc. of Pa.*, 745 F.2d 248 (3d Cir. 1984). The plan was similar to the plans for doctors--member dentists agreed to accept a set percentage of the UCR as full payment for treating Blue Shield subscribers. A subscriber's payments to a non-member dentist would be reimbursed at the same rate, but the subscriber would be personally responsible for amounts charged above the UCR. *Id.* at 253.

The bylaws of Blue Shield provided for a board comprised of 16 lay persons and 16 doctors. Only two members of the 32 were dentists. *Id.* The Third Circuit held that to sustain its claim, the plaintiff would have to show that member dentists, through their majority membership on two Blue Shield committees, actually controlled the UCR system. *Id.* at 256. Since it found that the committees were advisory only and real control was vested in the board, and since dentists accounted for only

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[4] Although the decision in *Virginia Academy* predates *Maricopa County* by two years, the Fourth Circuit's opinion followed substantially similar reasoning.

one-sixteenth of that body, the court upheld the district court's grant of summary judgment. *Id.* at 258-59. The court distinguished *Virginia Academy*, noting that the evidence in that case tended to show physician control. *Id.* at 257.

In the case before us, the district court granted summary judgment to OPS on the price-fixing claim on the ground that the majority of the OPS board, although physicians, did not compete economically with appellants for the provision of foot care in the relevant market. The court also found no evidence that any OPS members who did compete with appellant had conspired with OPS trustees. The court also ruled as a matter of law that under *Barry*, "health care plans like the OPS/BCBSO plan described here do not violate antitrust laws."

On the record before us, we cannot agree. Read together, *Maricopa County, Barry, Royal Drug, Virginia Academy* and *Pennsylvania Dental* stand for the broad proposition that health care plans may reimburse members and nonmembers differently, both in price and manner, so long as physicians (or the relevant group of competitive providers) do not control the health care plan. In *Barry*, it was because the plaintiffs had failed to produce any evidence of physician control of the price-setting entity that we upheld the agreement as to prices and reimbursement. We fully recognized, however, that "a horizontal agreement among competing physicians . . . is per se unlawful under section 1" and *Maricopa*. *Barry*, 805 F.2d at 868. Likewise, *Royal Drug* upheld the challenged practice because it did not arise from an agreement "between *competitors*." *Royal Drug*, 737 F.2d at 1436 (emphasis added). Conversely, the *Virginia Academy* court did find proscribed activity where the health plans at issue were mere "agents of their member physicians." *Virginia Academy*, 624 F.2d at 480.

Based on the evidence plaintiffs have so far produced, their case is more akin to *Maricopa* than to *Barry*. They have shown, for instance, that physicians formed a majority of the board for many of the years in question.[5] They have also alleged that physicians who practice in any of 20 specialties perform procedures that podiatrists perform.[6] Accordingly, many doctors are direct competitors to podiatrists, at least as to some of their services.

The district court stated that the majority of the OPS board did not, in fact, compete economically with the appellants in Portland. The court found that on a "typical" OPS board in the relevant years, a majority of trustees did not practice in Portland, and that many others had retired from practice. Accordingly, it concluded that a majority of trustees "would have no economic interest in restraining trade in the provision of foot care services in Portland."

Even if board members did not compete directly with the appellants, it cannot be determined as a matter

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5 The district court found that a 1978 amendment to the OPS bylaws required 50 percent non-physician members on the OPS board.

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6 The twenty listed specialties are: "(1) allergists, (2) anesthesiologists, (3) cardiovascular disease specialists and surgeons, (4) dermatologists, (5) endocrinologists, (6) family practitioners, (7) geriatric specialists, (7a) hematologists, (8) general practitioners, (9) diagnosis and internal medicine specialists, (10) infectious disease specialists, (10a) industrial practice specialists, (11) neurologists and neurosurgeons (12) oncologists, (13) orthopedic surgeons, (14) pathologists, (14a) physical medicine-rehabilitation specialists, (15) pediatricians, (16) plastic surgeons, (17) radiologists, (18) rheumatologists, (19) general surgeons, and (20) vascular surgeons." Brief of appellants, at 14.

of law that the board members had no economic interest in restraining trade. The proper inquiry is not whether individual board members *themselves* were in actual competition with the complaining nonmembers. Rather, the proper inquiry is whether practitioners sharing substantially similar economic interests collectively exercised control of a plan under whose auspices they have reached agreements which work to the detriment of competitors. *See* generally *Maricopa County*, 457 U.S. 332.[7] The challenged plan in *Barry* passed muster because it was "not an organization of physicians." *Barry*, 805 F.2d at 868. Similarly, the fact that physicians held half of the board seats in *Pennsylvania Dental* was irrelevant where the only potential competitors of the plaintiffs--dentists--held but two of 32 seats. Indeed, the *Pennsylvania Dental* court contrasted the dentists' negligible power with the physicians' controlling position in *Virginia Academy*. *Pennsylvania Dental*, 745 F.2d at 257.

Appellants in this case have made a sufficient factual showing to survive summary judgment. Their evidence that physicians occupied a majority of the board seats supports at a minimum an inference that OPS is not an independent provider of health care. In other words, evidence might well be produced at trial that would cause a trier-of-fact to conclude that the OPS plan was, in fact, "an organization of physicians," *Barry*, 805 F.2d at 868, or an "agent[ ] of [its] member physicians," *Virginia Academy*, 624 F.2d at 480. Board members, even if not com-

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7 *See also Radiant Burners, Inc. v. Peoples Gas, Light & Coke Co.*, 364 U.S. 656, 657 n.1, 659-60 (1961) (though only six among "numerous" members of gas association directly competed with plaintiff, Sherman 1 claim was stated even in absence of proof that six direct competitors controlled association, because association members as a whole shared substantially similar economic interests).

peting directly with podiatrists, may have acted in their joint and reciprocal self-interest to approve a price-fixing agreement among those fellow physicians who did compete directly. The lack of evidence of an overt conspiracy is not dispositive. If the OPS plan was, in fact, a horizontal agreement among competitors, it was unlawful per se. *See Barry*, 805 F.2d at 868.

We conclude that, construing the evidence in the light most favorable to appellants, the district court acted precipitously in ruling as a matter of law that they were not entitled to judgment.

B. *Group Boycott*

Appellants also claim that they have made a prima facie showing that the exclusion of podiatrists from OPS, taken together with the discriminatory reimbursement policies for their services as non-members, constitutes a "group boycott" under Section 1.

Group boycotts, sometimes called concerted refusals to deal, commonly are considered business practices that merit per se invalidation under section 1. *Northwest Wholesale*, 472 U.S. at 290. However, the Supreme Court has cautioned lower courts not to be overinclusive in defining the categories of refusals to deal that amount to per se violations. "Cases to which this Court has applied the *per se* approach have generally involved joint efforts by a firm or firms to disadvantage competitors by 'either directly denying or persuading or coercing suppliers or customers to deny relationships the competitors need in the competitive struggle.' " *Id.* at 294, quoting L. Sullivan, Law of Antitrust 261-62 (1977).

Northwest Wholesale identified three characteristics as indicative of per se illegal boycotts: (1) the boycott

cuts off access to a supply, facility, or market necessary to enable the victim firm to compete; (2) the boycotting firm possesses a dominant market position; and (3) the practices are not justified by plausible arguments that they enhanced overall efficiency or competition. *Id.* Under these or similar circumstances, the Court held, the danger of anticompetitive injury was sufficiently great that per se treatment was warranted. *Id.*[8]

In the absence of such a showing, however, the Court has since admonished that the category of activities comprising group boycotts "is not to be expanded indiscriminately." *FTC v. Indiana Federation of Dentists*, 476 U.S. 447, 458 (1986). Of particular relevance to this case, the Court added: "Moreover, we have been slow to condemn rules adopted by professional associations as unreasonable *per se* . . . and, in general, to extend *per se* analysis to restraints imposed in the context of business relationships where the economic impact of certain practices is not immediately obvious." *Id.* at 458-59.

However, the Court has not evidenced a similar reluctance to apply a rule of reason analysis to strike down rules of professional associations. In *Indiana Federation of Dentists,* the dentists formed a federation to continue the Indiana Dental Association's former policy of refusing to submit x-rays to dental health insurers with dental claim forms. Insurers requested the x-rays so that their administrators could determine whether the recommended course of treatment was reasonable. Applying a rule of reason test, the Court ruled that the Federation's practice violated the antitrust laws.

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8 The Court's approach seems to suggest that the facts be developed as in a rule of reason case, or at least almost as fully, in order to determine whether the conduct is per se illegal.

Barry is instructive on the approach in this circuit to group boycott claims against professional organizations. The court applied rule of reason analysis to determine the effect on competition of Blue Cross's agreement with physicians. The *Barry* plaintiffs argued that the Blue Cross plan had the effect of boycotting nonmember physicians by interfering with their access to subscribers. Since nonmember services were reimbursed at a lower rate, the difference to be paid by the individual patient, they contended, few patients would consent to referral to a nonmember; this was tantamount to a refusal to deal. We rejected this argument, reasoning that the diversion of patients from other physicians was little different from

> the ordinary consequence of every commercial contract . . . When a consumer contracts to buy services from one health plan, the consumer will then have little or no demand for the services of a nonparticipating physician, especially if the consumer would have to pay more for those services. The contract does not mean that the parties have agreed to an unlawful concerted refusal to deal.

Barry, 805 F.2d at 872. In upholding the practice, however, we took pains to distinguish *Virginia Academy*, in which there was also an allegation of boycott:

> [i]n that case, Blue Shield reimbursed for psychologists' services only when billed through a member physician. Psychiatrists, who compete with psychologists, did not face this obstacle because, as medical doctors, they could simply become members of Blue Shield. By contrast, in the present case, Blue Cross *does not discriminate* against a

particular class of medical provider, but instead is willing to purchase services from all physicians on equal terms.

Id. at 873 (emphasis added).

Obviously, the fact that OPS *does* discriminate against a class of providers distinguishes this case from *Barry*. While, standing alone, OPS's two-tier fee system could probably withstand a "boycott" challenge under *Barry*, when coupled with OPS's long refusal to admit podiatrists, it is doubtful whether OPS was, in fact, "willing to purchase services from all [practitioners] on equal terms." *Id.*

OPS has the burden under *Barnes* of putting forward a plausible, justifiable explanation for its conduct. It stipulated that it would "not defend this case in any way on the basis that the quality of health care provided by podiatrists is inferior to that provided by other providers of health care." Instead, it claims that "problems with podiatrist claims overutilization"[9] motivated its decision to exclude podiatrists from membership. Brief of Appellee at 9. Even if this is a plausible and legitimate basis for exclusion, we find that appellants sustained their burden under *Barnes* of raising a reasonable inference, grounded in evidence, to refute OPS's claimed justification. Again without deciding any factual issues, we note that the record includes testimony from a former OPS board member, Dr. Price, suggesting that the exclusion of podiatrists was prompted neither by considerations of cost nor by fears of overbilling. Appellants have also pro-

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9 It is unclear whether the contention is that patients sought unnecessary care or that podiatrists performed unnecessary procedures.

duced evidence that the overall costs for foot procedures performed by podiatrists were lower than those of OPS members. *See* Reply Brief of Appellants at 13-14.

Viewing the evidence in the light most favorable to appellants, we must conclude that they are entitled to go to trial on their group boycott theory. Whether ultimately the conduct can be sustained as justified or should be condemned either as a per se violation or under a rule of reason analysis should be determined after a fully developed record at trial. Summary judgment should not have been granted.

CONCLUSION

Appellants asked that we direct the district court to enter summary judgment in their favor. We conclude that genuine issues of material fact remain. In such a case that is rife with factual complexity, summary judgment for either side is rarely justified. *See Barnes*, 759 F.2d at 681. Accordingly, we decline appellants' invitation, reverse the summary judgment in favor of OPS and remand for trial.

REVERSED and REMANDED.

App. C

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CLERK, U.S. DISTRICT COURT
DISTRICT OF OREGON
By _____

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

JOHN HAHN, WADE LIGGETT, JOSEPH AIZAWA, V. G. LIVINGSTON, HUGH FRAZER, and HIDE AIZAWA,	)	
Plaintiffs,	)	Civil No. 78-887 LE
v.	)	ORDER
OREGON PHYSICIANS' SERVICE, an Oregon nonprofit corporation; and PHYSICIANS' ASSOCIATION OF CLACKAMAS COUNTY, an Oregon corporation,	)	
Defendants.	)	

Plaintiffs John Hahn, Wade Liggett, Joseph Aizawa, V.G. Livingston, Hugh Fraser, and Hide Aizawa, all podiatric physicians, brought this action against the Oregon Physicians' Service alleging a combination or

conspiracy in restraint of trade and monopoly, attempted monopoly, and a combination or conspiracy with other persons to monopolize, all in violation of the Sherman Antitrust Act, 15 U.S.C. §§ 1 and 2. The podiatrists move this court for summary judgment on the issue of liability and alternatively, for partial summary judgment pursuant to Fed. R. Civ. P. 56 (a). They also move the court for leave to file a third amended complaint to add plaintiffs' professional service corporations as plaintiffs and Blue Cross/Blue Shield of Oregon as a defendant. The Oregon Physician's Service (OPS) also moves for summary judgment in its favor on the issue of liability.

FACTS

Plaintiffs are doctors of podiatric medicine (D.P.M.s) licensed to practice podiatry in Oregon under O.R.S. Chapter 682. O.R.S. 682.101(3) provides that " 'Podiatry' means the diagnosis or the medical, physical or surgical treatment of ailments of the human foot . . ." Podiatrists may perform all foot procedures that medical doctors (M.D.s) and doctors of osteopathic medicine (D.O.s) perform, with the exceptions of administering general or spinal anesthetics and amputating the foot.

In the early 1970's several plaintiffs applied for membership in OPS. OPS was a prepaid health care plan which directly reimbursed its member physicians for their services to subscribers to the plan. Representatives of OPS advised plaintiffs who applied that podiatrists were not eligible because OPS membership was limited to doctors of medicine and osteopathy.[1]

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[1] The amended Articles of Incorporation state OPS membership is limited to "physicians and surgeons licensed to practice medicine and surgery in the State of Oregon by the

In 1981, OPS had 286,218 subscribers. Blue Cross/Blue Shield of Oregon (BCBSO) merged with OPS in 1983, and as the survivor corporation, expressly assumed all OPS's rights, obligations and liabilities. BCBSO continued OPS' practice of not admitting podiatrists as members of its plan. In 1985, BCBSO had over 800,000 subscribers.

In 1978, a group of podiatrists created the Fair Action Committee for Education, Inc., (FACE) as a nonprofit corporation to which certain podiatrists assigned any legal rights they had under the Sherman Act. Five of the six named plaintiffs here assigned their claims to FACE.

FACE brought four separate actions against twelve prepaid health care plans, including OPS, for violations of the Sherman Antitrust Act. After numerous court actions and settlement negotiations, OPS is the only defendant remaining.[2] On June 27, 1986 the Honorable Gus J. Solomon bifurcated the issues of damages and liability for trial.

In 1980 FACE dissolved. Before its dissolution, the complaint was amended to substitute the named individual podiatrists for FACE in view of OPS' contention that FACE was not the real party in interest and therefore, had no standing.

(Footnote 1 continued)

Oregon State Board of Medical Examiners . . ." The trustees of OPS adopted this amendment to their Articles of Incorporation and executed it on March 7, 1953.

2 Plaintiffs request to file a third amended complaint which adds BCBSO as a defendant.

As non-members of OPS and its successor BCBSO,[3] podiatrists who render services to OPS subscribers are reimbursed different from OPS members. OPS directly reimburses its member physicians at up to the 90th percentile of full reimbursement of other physicians of similar specialty. In contrast, when a non-member physician renders service to an OPS subscriber, OPS issues payment to the subscriber at the 60th percentile of full reimbursement. The non-member physician must collect that amount from the subscriber, and may bill for the balance of the value of his or her services. OPS members may not bill for the balance of their services by agreement with OPS/BCBSO.

The podiatrists claim the effect of this difference in reimbursement amount and method "is that in each case [the podiatrist] will receive less money than if the full allowance available to members was paid." Plaintiffs' memorandum in support of the motion for summary judgment, p. 16. They claim they have lost and will continue to lose clients who subscribe to OPS because OPS will not pay in full for services rendered to those clients.

The plaintiffs claim they are forced to compete unfairly with OPS member physicians for clients who need foot care in the Portland metropolitan area because OPS/BCBSO refused to admit them as members or to reimburse them in the same fashion as members. The podiatrists allege OPS is "dominated and controlled" by their direct competitors, M.D.s and osteopaths. By virtue

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3 In August 1985, BCBSO allowed podiatrists to become members for the first time. The second amended complaint and this opinion describe conditions before podiatrists were admitted as BCBSO members.

of this domination and control, plaintiffs claim the M.D.s and osteopaths in OPS have conspired to boycott podiatrists, to fix prices, and to monopolize foot care services in the Portland metropolitan area, all in violation of the Sherman Antitrust Act, 15 U.S.C. §§ 1 and 2.

LEGAL STANDARDS

Summary judgment is appropriate when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c).

All reasonable doubts as to the existence of genuine issues of material fact should be resolved against the moving party. Hector v. Wiens, 533 F.2d 429, 432 (9th Cir. 1976). A material issue of fact is one that affects the outcome of the litigation and requires a trial to resolve the parties' differing versions of the truth. United States v. First National Bank, 652 f.2d [sic] 882, 887 (9th Cir. 1981).

DISCUSSION

Plaintiffs contend a horizontal agreement[4] existed among their direct competitors, the physican members of OPS's Board of Trustees, to restrain trade and monopolize foot care services in the Portland area. Evidence plaintiffs present of the alleged conspiracy includes the domination of the OPS Board of Trustees by a physician majority; selection of physician Board mem-

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4 Plaintiffs claim OPS is merely an agent of the member physicians who dominate and control it. Therefore, they claim a horizontal rather than a vertical agreement accurately describes the type of conspiracy they allege.

bers by local medical societies and the Oregon Medical Association; a Medical Advisory Committee of the Board of Trustees with jurisdiction over issues of membership application which was either exclusively or mostly M.D.s; and members' acknowledgment and agreement to be bound by the OSP [sic] Articles of Incorporation and Bylaws, including those provisions relating to the exclusion of non-M.D.s and D.O.s.

Plaintiffs state that under the domination and control of its physician members, the OPS Board in 1982 specifically rejected podiatrists as members and in 1972 decided to reimburse podiatrists at the same lower level as non-member physicians.

15 U.S.C. § 1 Claim

Section 1 of the Sherman Act, 15 U.S.C. § 1, prohibits "every contract, combination * * * or conspiracy, in restraint of trade or commerce * * *." To establish a violation of Section 1, plaintiffs must prove defendants engaged in concerted action. Therefore, in a motion for summary judgment directed against them, plaintiffs must allege sufficient facts to raise a reasonable inference of an illegal combination or conspiracy to overcome the motion. Filco v. Amana Refrigeration, Inc., 709 F.2d 1257, 1261 (9th Cir. 1983).

I find plaintiffs do not present sufficient facts to raise a reasonable inference of an illegal combination or conspiracy on the part of the OPS Board or its member physicians to restrain trade in the provision of foot care services in the Portland metropolitan area. The record before me demonstrates the majority of the OPS Board of Trustees in the relevant time periods is not competing economically with plaintiff podiatrists for the provision of foot care in this market area. Plaintiff John

Hahn practices podiatry in Tigard, Oregon. Plaintiff Joseph Aizawa practices podiatry in Milwaukie, Oregon. Plaintiffs Wade Liggett, Hide Aizawa, and V.G. Livingston practice podiatry in Portland, Oregon. V.G. Livingston also practices in Vancouver, Washington.

In contrast, the majority of the physicians on a typical OPS Board of Trustees does not practice in the Portland metropolitan area and does not specialize in foot care.[5]

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[5] A list of the 1976 OPS Board of Trustees shows the location and type of practice of each trustee:

1976

William C. Scott, M.D., Chairman, Portland, Internal Medicine
Thomas E. Matheson, M.D., Vice Chairman, Prineville, Family Practice
John R. Higgins, M.D., Secretary, Baker, Family Practice
Henry D. Barker, M.D., Newport, Family Practice
Berton D. Braly, M.D., Corvallis, Anesthesiologist
Dean Bryson, Salem, Associate Justice Supreme Court of Oregon
J. Don Chapman, Portland, Regional Administrator, Small Business Administration
William W. Cook, Portland, Vice President, U. S. National Bank
Robert R. Cooper, M.D., Salem, Family Practice
Delbert R. Ellis, Portland, President Amfac Mortgage Co.
Robert H. Elsner, Portland, Association Executive
John T. Flaxel, M.D., Bend, Ophthalmology
Robert C. Kennedy, Portland, President, Oregon AFL-CIO
Albert M. Lewis, M.D., Forest Grove, Surgery
C. Gary Loosli, M.D., St. Helens, Family Practice
Anthony Meeker, Amity, Agri-business
Martin D. Merriss, M.D., The Dalles, Surgeon
Robert R. Mooers, M.D., Roseburg, Family Practice
Thomas L. Morris, Portland, Investment Advisor
Max H. Parrott, M.D., Portland, OB-GYN
Timothy A. Patrick, M.D., Astoria, Surgery

Some Board members are not physicians, and OPS presents evidence uncontroverted by plaintiffs that some of the physicians were retired during their terms as trustees. In addition, a 1978 amendment to the OPS Bylaws required fifty percent non-physician members of the OPS Board. Even if it assumed the trustees determined the membership and reimbursement issues for OSP [sic], they would have no economic interest in restraining trade in the provision of foot care service in Portland. Pa. Dental Ass'n v. Medical Service Ass'n of Pa., 745 F.2d 248, 258 (3rd Cir. 1984), cert. denied, 105 S. Ct. 2021 (1985) (no horizontal conspiracy exists when only 1/16th of the decision-makers are competitors in the relevant market).

Plaintiffs present no evidence that any OPS member physicians who were their direct competitors for foot care in the Portland metropolitan area conspired with any OSP [sic] Board of Trustees. Under these circumstances, no facts raise a reasonable inference of any illegal combination or conspiracy to overcome OPS' motion for summary judgment on a violation of 15 U.S.C. § 1.

On the contrary, plaintiffs present evidence that OPS subscribers go to both OPS physicians and to non-member podiatrists despite the fact these subscribers

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(Footnote 5 continued)

William D. Proppe, Ph.D., Portland, Superintendent, Washington County Education Service District
William E. Purnell, M.D., Salem, Family Practice
Weldon T. Ross, M.D., McMinnville, Family Practice
Estes Snedecor, Jr., Portland, Vice Pres., Portland General Electric
Marvin J. Urman, M.D., Portland, Family Practice
Julius Varga, M.D., Albany, County Health Officer
W. Rich Warrington, M.D., Portland, Surgeon

are not fully reimbursed for podiatric treatment. Plaintiffs present an exhibit prepared from computer reports showing that in 41 instances in 1979-1980 an OPS subscriber chose to visit both a podiatrist and an OPS M.D. for foot care. This information demonstrates OPS subscribers with foot problems exercise free choice in selecting a podiatrist or physician for treatment. Further, the podiatrists were highly successful in collecting balances due from the subscribers for the full value of the treatment provided. These facts show competition to provide foot care services in Portland is healthy and needs no protection from antitrust law. Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc., 429 U.S. 477, 488 (1977).

The Ninth Circuit has recently held that health care plans like the OPS/BCBSO plan described here do not violate antitrust laws. Barry v. Blue Cross of California, slip opinion No. 85-6448, Dec. 4, 1986.

Based on the facts of this case, which fail to show any evidence of a horizontal agreement to restrain trade among OPS physicians, and Barry v. Blue Cross, I find no violation of Section 1 of the Sherman Antitrust Act.

15 U.S.C. § 2 Claim

The podiatrists also claim OPS has monopolized or attempted to monopolize the foot care services market in the Portland metropolitan area in violation of Section 2 of the Sherman Antitrust Act. To prevail on the monopoly claim they must establish OPS had a sufficiently large share of a relevant market. Barry v. Blue Cross of California, slip opinion No. 85-6448, Dec. 4, 1986 at 17. The OPS prepaid health care plan covered only 15 or 16% of the individuals in the Portland Metropolitan area at any one time. Such a market share

is far below what is required for a monopoly. See Forro Precision, Inc. v. International Business Machines Corp., 673 F.2d 1045, 1058 (9th Cir. 1982) (a thirty-five percent market share did not permit an inference of monopoly power), cert. denied, 105 S. Ct. 2664 (1985).

Proof of an attempt to monopolize requires three elements: (1) specific intent to control prices or destroy competition with respect to a part of commerce, (2) predatory or anticompetitive conduct directed to accomplishing the unlawful purpose, and (3) a dangerous probability of success. Purex Corp. v. Proctor & Gamble Co., 596 F.2d 881, 890 (9th Cir. 1978). Plaintiffs prove none of these elements given the facts that the OPS Board of Trustees does not compete with the plaintiff podiatrists, and OPS has such a small share of the market.

No genuine issues of fact exist with respect to plaintiffs' claims under 15 U.S.C. §§ 1 and 2.

The issue of standing need not be discussed given the disposition of this case.

IT IS ORDERED that defendant OPS' motion for summary judgment on the issue of liability is GRANTED. Plaintiffs John Hahn, Wade Liggett, Joseph Aizawa, V.G. Livingston, Hugh Fraser and Hide Aizawas' motion for summary judgment and for partial summary judgment is DENIED. IT IS FURTHER ORDERED that plaintiffs' motion to file a third amended complaint to add plaintiffs' professional corporations as plaintiffs and BCBSO as a defendant is denied.

Dated this 10th day of February, 1987.

/s/ EDWARD LEAVY
United States District Judge

App. D

U.S. DISTRICT COURT
DISTRICT OF OREGON
F I L E D
MAR 10, 1989
ROBERT M. CHRIST, CLERK
BY DEPUTY

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

JOHN HAHN, WADE LIGGETT, et al,	)	
	)	
Plaintiffs-Appellants,	)	
	)	
vs.	)	
	)	
OREGON PHYSICIANS' SERVICE, et al	)	No. 87-3875
	)	
Defendants-Appellees.	)	CV 78-0887-LE

APPEAL from the United States District Court for the _____ District of _____

THIS CAUSE came on to be heard on the Transcript of the Record from the United States District Court for the Portland District of Oregon and was duly submitted.

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court, that the _____ judgment of the said District Court in this Cause be, and hereby is REVERSED AND REMANDED.

Filed and entered 11/4/88 (Amended 2/27/89)

App. E

FILED

MAR 31 1989

CATHY A. CATTERSON, CLERK
U.S. COURT OF APPEALS

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

JOHN HAHN; WADE LIGGETT; JOSEPH AIZAWA; V.G. LIVINGSTON; HUGH FRASER; HIDE AIZAWA,	)	
Plaintiffs-Appellants,	)	No. 87-3875
v.	)	CV 78-0887-LE
OREGON PHYSICIANS' SERVICE; PHYSICIANS' ASSOCIATION OF CLACKAMAS COUNTY,	)	ORDER
Defendants-Appellees.	)	

BEFORE: HUG, FLETCHER, and NELSON, Circuit Judges.

Appellee's petition for rehearing of amended opinion is dēnied.

App. F

[¶ 66,849] Irving Ear, Nose, Throat & Allergy Clinic, et al v. Group Hospital Service, Inc., et al.

U. S. Court of Appeals, Fifth Circuit, No. 84-1404. Dated October 31, 1985. Appeal from U. S. District Court, Northern District of Texas.

Before RANDALL, HILL and DAVIS, Circuit Judges.

[OPINION]

DAVIS, Cir. J.: Appellants, Herbert R. Kasnetz, M.D., an ear, nose, throat and allergy specialist, and his clinic Irving Ear, Nose, Throat & Allergy Clinic, brought this action against three Texas corporations doing business as Blue Cross/Blue Shield of Texas, alleging violations of Section 1 of the Sherman Act, 15 U.S.C. § 1. The district court directed a verdict in favor of the defendants. For the reasons set forth below, we affirm.

I.

The pertinent facts are undisputed. The three defendants to this action, Group Hospital Service, Inc. (GHS), Group Life & Health Insurance Company (GL&H), and Group Medical & Surgical Service (GM & SS), are licensed to operate under the service mark Blue Cross/Blue Shield of Texas. GHS was chartered in 1939 under Article 20 of the Texas Insurance Code as a non-profit hospital service company. GHS writes individual and group hospital plans. GL&H is a wholly-owned subsidiary of GHS, which was acquired by GHS in 1976. Since 1976, GL&H has underwritten group medical and surgical policies to complement the hospitalization

policies written by GHS. GHS formed the third defendant, GM & SS, as a statewide mutual assessment, nonprofit corporation under Article 14 of the Texas Insurance Code. This entity is owned by its policy holders. Before 1976, when GHS acquired GL&H, GM & SS marketed individual medical and surgical policies; after GHS acquired GL&H, GM & SS stopped writing new business and limited its activity to servicing existing contracts.

The officers of the three defendants operating under the Blue Cross/Blue Shield umbrella are identical. All sales and claims employees are carried on the payroll of GHS and they perform functions, as required, for all three companies. The twenty directors of GHS also serve on the boards of GL&H and GM & SS. The latter two entities have three additional directors. Common board meetings are held for all three entities.

Blue Cross/Blue Shield of Texas instituted a cost containment program in 1976 in which it undertook to reimburse physicians fees on the basis of what is considered usual, customary, and reasonable (UCR) fees. Defendants established UCR fees for a number of individual medical procedures by reviewing actual fees charged by a large number of physicians practicing in a geographic area. It also evaluated physicians' patterns of practice to assess how often specific procedures were performed for a given number of patients. With this information, the insurer identified physicians who sought to charge fees it considered excessive or who performed medical services of questionable necessity. The insurer suggested that those physicians so identified reduce their charges and services to the acceptable range. If the physician did not agree to do so, the insurer declined to pay the physician and exercised the right granted to it in its policy to directly reimburse patients for services

provided by these physicians based on the UCR charge.[1] In addition, claims for those physicians' services were subjected to closer prepayment scrutiny than that customarily given.

Kasnetz operated his ear, nose, throat and allergy clinic in Irving, Texas. Approximately one-third of his patients were insured by Blue Cross/Blue Shield. Until 1976, Kasnetz billed Blue Cross/Blue Shield directly for payment of patient services and the insurer routinely reimbursed the physician. In 1976, however, the insurer identified Kasnetz as a physician who performed medically unnecessary procedures and who assessed multiple charges for essentially the same services. The insurer informed Kasnetz that payment for covered services for its policy holder would be made to the policy holders and not to Kasnetz, and then only after prepayment review.

Kasnetz brought this action complaining that the insurer's cost containment program, which led to a reduction in his income and the size of his practice, violated Section 1 of the Sherman Act. He alleged: (1) horizontal and vertical price fixing; (2) horizontal group boycott; and (3) restraint of trade. At the close of the plaintiff's case after five days of jury trial, the district court directed a verdict in favor of the defendant insurer. The district court concluded that the evidence was insufficient to establish a conspiracy because the three defendants were a single economic entity incapable of conspiracy; alternatively, the district court assumed the defendants had the capacity to conspire and nevertheless found evidence of a Sherman Act violation insufficent to raise a jury issue.

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1 Blue Cross/Blue Shield's standard policy provided for payment of a specific percentage of the reasonable charges for medically necessary services.

II.

A.

We review this appeal from a directed verdict under the familiar *Boeing* standard and consider:

> [A]ll of the evidence--not just that evidence which supports the non-mover's case--but in the light and with all reasonable inferences most favorable to the party opposed to the motion. If the facts and inferences point so strongly and overwhelmingly in favor of one party that the Court believes that reasonable men could not arrive at a contrary verdict, granting of the motions is proper.

Boeing Co. v. Shipman, 411 F. 2d 365, 374 (5th Cir. 1969) (en banc).

To prevail under Section 1 of the Sherman Act, plaintiff must show a contract, combination or conspiracy, in restraint of trade or commerce. 15 U.S.C. § 1.

The district court based its decision that the defendant corporations lacked the capacity to conspire on the notion that the three defendants acted as a single entity. The defendants contend that *Copperweld Corp. v. Independence Tube Corp.* [1984-2 TRADE CASES ¶ 66,065], ___U. S.___, 104 S. Ct. 2731, 81 L. Ed. 2d 628 (1984), supports the district court's ruling and is controlling. In *Copperweld*, the Court held that a parent corporation and its wholly-owned subsidiary have a "unity of purpose or a common design" and are incapable of conspiring with each other. See also *Century Oil Tool, Inc. v. Production Specialties, Inc.* [1984-2 TRADE CASES ¶ 66,136], 737 F. 2d 1316 (5th Cir. 1984). Under the teaching of *Copper-*

weld, the district court was clearly correct in concluding that GHS and its wholly-owned subsidiary, GL&H, are incapable of conspiring with each other. Because the alternate ground for the district court's ruling is solidly grounded in established law, we find it unnecessary to decide whether *Copperweld* should be extended to hold that GM & SS is incapable of conspiring with the other two defendants.

B.

In his complaint and in his brief on appeal, Kasnetz alleged per se violations of Section 1 by defendants in agreeing to fix prices and to conduct a horizontal boycott.[2] In addition, he alleged a conspiracy in restraint of trade, a Section 1 claim to be tested under the rule of reason. At oral argument, Kasnetz conceded that he had failed to establish a per se violation of Section 1 but argued that under the rule of reason, he had presented sufficient evidence to have his case submitted to the jury. We agree with the conclusion of the district court that insufficient evidence was adduced to present a jury issue

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2 Actions identified by courts as per se violations include price fixing agreements and horizonal group boycotts and are presumed to have a pernicious effect on competition. Once per se illegal activity is shown, no evidence need be presented of anti-competitive effects. *Northern Pacific Ry. Co. v. United States* [1958 TRADE CASES ¶ 68,961], 356 U. S. 1, 5, 78 S. Ct. 514, 2 L. Ed. 2d 545 (1958).

on plaintiff's restraint of trade claim under a rule of reason analysis as well as his claim of a per se violation.[3]

To survive a motion for directed verdict on the restraint of trade claims, analyzed under a rule of reason, Kasnetz was required to adduce evidence tending to show that the alleged agreement has an effect on competition among physicians in his geographic area; he was required to present evidence of "antitrust injury, . . . injury of the type the antitrust laws were intended to prevent and flows from that which makes defendants' acts unlawful; the injury must reflect the anticompetitive effect either of the violation or of anticompetitive acts made possible by the violation." *Brunswick Corp. v. Pueblo Bowl-O-Mat*, [1977-1 TRADE CASES ¶ 61,255], 429 U. S. 477, 489, 97 S. Ct. 690, 50 L. Ed. 2d 701 (1777) [sic].

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3 The district court's decision to direct a verdict on the alleged per se violations is clearly correct on the undisputed facts presented in this case. The three defendants did not compete with each other, or hold themselves out as competitors: Also, Kasnetz provided medical services and did not sell health insurance so Kasnetz did not compete with the three defendants. Thus, no evidence of horizonal price fixing or illegal boycott by defendants was adduced. See *Plueckhahn v. Farmers Ins. Exchange* [1985-1 TRADE CASES ¶ 66,338], 749 F. 2d 241, 245 (5th Cir. 1985); *Blackburn v. Crum & Forster* [1980-1 TRADE CASES ¶ 63,164], 611 F. 2d 102, 104 (5th Cir.), cert. denied, 447 U. S. 906 (1980). Likewise, because Kasnetz sold no products, goods or services supplied him by the defendants, no evidence of a vertical link necessary to establish vertical price fixing (as in resale price maintenance) was presented. See *Royal Drug Co. v. Group Life & Health Ins. Co.* [1984-2 TRADE CASES ¶ 66,137], 737 F. 2d 1433, 1438 (5th Cir. 1984), cert. denied, 105 S. Ct. 912 (1985).

Kasnetz presented evidence in support of his contentions that the insurer's cost containment program injured his practice and reduced his income but he did not demonstrate injury to competition in the market area. He showed that the insurer's effort to reduce medical costs had the effect of reducing the number of patients who came to him for care; those who had difficulty with reimbursement stopped using his services and no longer referred friends to him. Kasnetz did not show, however, that Blue Cross/Blue Shield's program affected competition among physicians of his specialty or among any physicians in his geographic area. Thus, Kasnetz utterly failed to present proof from which a reasonable person could infer an unreasonable restraint of trade.

Affirmed.